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ACROSS THE PAGES . . .

IN THE MISSION INTENTION for this month the Holy Father asks us the pray especially for the eighty million Mohammedans living in India. "Islam Is Brotherhood" points to a way whereby these people of Allah can be brought to know and love the true Faith.

CHOTA BUKHAR—malaria to you— is health problem number one in India. To make India malaria-free is a gigantic task—but, as Sister Leonie Tummers, M. D. shows us, it can be done. Beginnings are being made . . .

"IF HER SICK COULD BE CURED, India would be one of the healthiest places in the world," writes Sister Elise Wijnen, M.D.. And to prove her point she gives some of the many illnesses and cures she meets in the "Daily Review."

AN ADEQUATE PUBLIC HEALTH PROGRAM FOR INDIA is one of the objectives of the Bombay Plan. We have summarized briefly some of the main proposals of the Plan as they relate to medicine and public health.

YOUR WILL . . . . .

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $..... for its general purposes."

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The Society of Catholic Medical Missionaries is a religious community of women founded in 1925 for the purpose of providing medical care to the sick in the foreign missions.

The Motherhouse and Novitiate are located in Fox Chase, Philadelphia, Pa. There is also a House of Studies in Brookland, Washington, D.C., and Houses of Postulate in England and Holland.

The main activities of the Society include the conducting of hospitals, dispensaries, maternity and child welfare centers, training schools for native nurses and midwives, and similar health works.

Medical Mission Centers conducted by the Society in India and the United States are:

Holy Family Hospital, Rawalpindi, India
Holy Family Hospital, Patna, India
Mitford Muncipal Hospital, Dacca, Bengal, India
The Santa Fe Catholic Maternity Inst., Santa Fe, N.M.
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It is the purpose of the Society to send Medical Missionaries to any mission field of the world. The Society has many requests; it needs many vocations.

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Cutting the Coat to the Cloth

It all depends on the cloth. But disinterested and all-embracing charity can fit itself to the needs.

Writing several months ago in the **Cathedral Record,** Archbishop Downey of Liverpool, England gave the following warning of the high cost of social reforms:

"Gradually the public is awakening to the outpouring of public funds envisaged by the grandiose schemes of the Government spending departments at a time when we shall be called upon to strive to lessen the present burden of taxation if we are to enter into successful competition in the trade markets of the world. Incidentally, we have yet to cope with the debt incurred by the war, for which we have already mortgaged the earnings of posterity.

"After the last war there was an orgy of spending, which was speedily followed by the greatest industrial and commercial slump the country has ever known. We are well aware of the need of social reforms which must be undertaken in the post-war years, and it seems to be forgotten that the nation, like the individual, will have to cut its coat according to its cloth."

There is no longer any doubt of the need. The long years of war have been for us also long years of discovery. For most of us, before the war, there were only places. Now there are peoples, and with the people, their needs—poverty, suffering, distress. There are the stricken countries of Europe, closest to us, of course, for the blood of Europe runs in our veins too.

And gradually now, very gradually, we are becoming aware of the Orient. Only thirty-six hours from New York to Bombay by air means only thirty-six hours away from the throbbing agony of India's masses and from the plea in their eyes for relief from the terrible burden they carry. It is the same for China, the Middle East, for brown-skinned peoples on tiny bits of rock and sand in the South Pacific, for all our neighbors—North, South, East and West.

No longer can we hold ourselves excused with—"We do not know." Everywhere we are told of these needs of other peoples in the press, the radio, the movies. To close our hearts to them and not to know, we should have to become ostriches, and an ostrich, his head in the sand, is not a pretty picture. It is all before us—this tremendous opportunity to rebuild where once we destroyed, to understand where once we were blind, to give where once we turned away.

Archbishop Downey of Liverpool warns us to cut the coat according to the cloth. If the cloth is to be taxation, if it is to be measured out in terms of profit and gain, well then, the cloth will be very poor quality indeed. To be sure, it will not stretch very far.

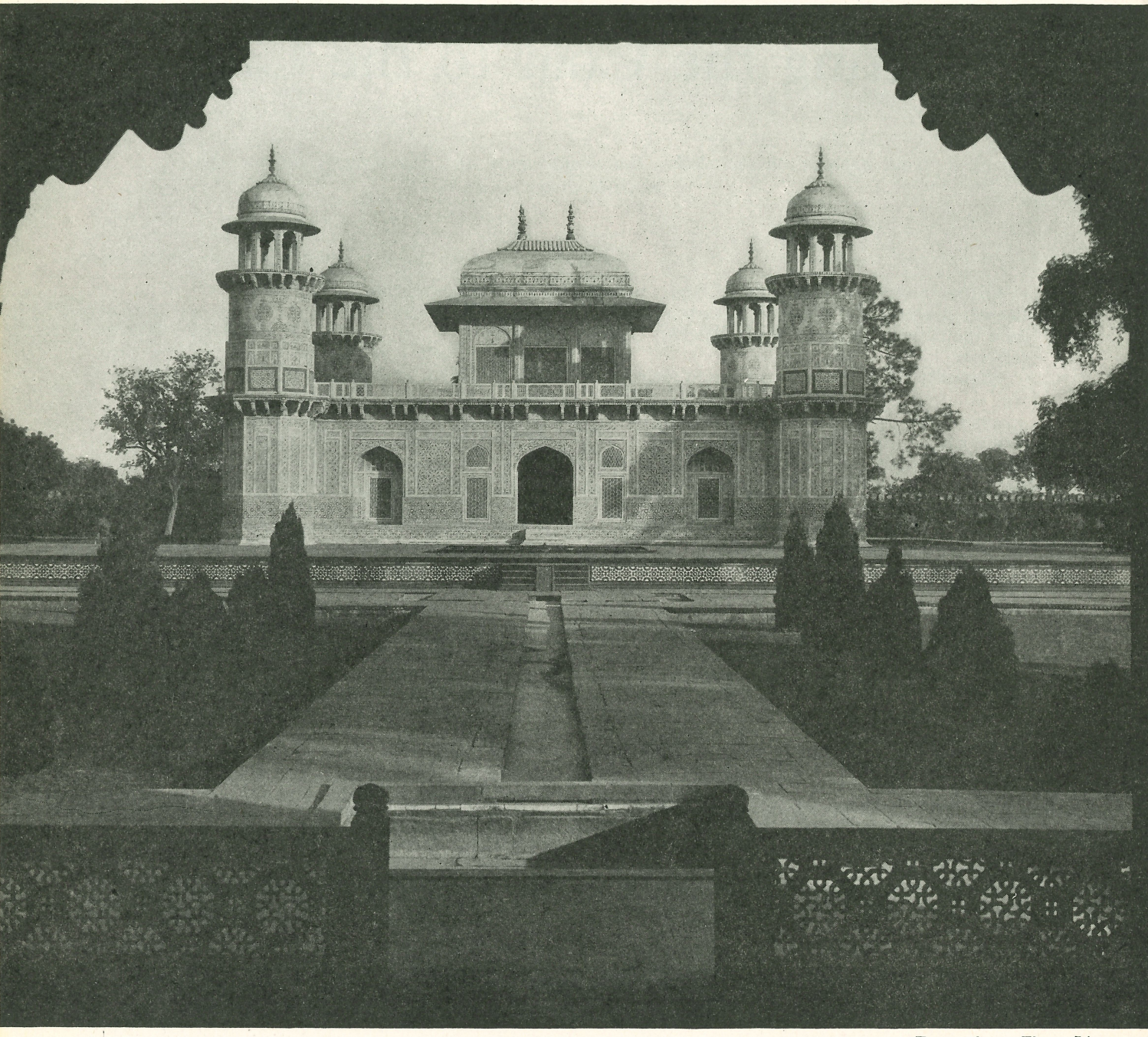
But there is a cloth of a different texture and weave, one that can reach to the ends of the earth and beyond—and it is charity. It is significant that Our Holy Father should have stressed this point in several of his recent addresses and letters. In thanking the United States and other governments for their aid to stricken countries he said: "While men of good-will are endeavoring to bridge the gulf and bring the peoples together, this purely disinterested act of charity assumes an aspect and a value of unique importance.

"When the dissonance of hate and discord will be but a tragic memory, the good effects of this victory of active and magnanimous charity over the poison of selfishness and enmity will ripen into even a larger harvest of good."

And again in an address given on this Passion Sunday to the peoples of Rome, the Holy Father urged—"For the love of Christ, join together in the spirit of brotherhood, lend a helping hand to one another, you who enjoy still or who have recently acquired a measure of the world's good and you who have tragically lost everything, in order that through mutual support you may overcome the economic crisis into which the country has fallen, and which would be ever so greatly relieved were all men united by truly human solidarity and by a real divine Christian charity."

Charity is the cloth the Holy Father would have us cut from—for it is the only one that will fit the world-wide needs of the present moment. Nor will it ever become threadbare with the wearing.

But to cut the cloth is not all. There must also be those who will volunteer, through personal and disinterested service, to do the fitting. We have seen millions of young people answer the call to arms, volunteers in the name of patriotism. Can we count upon them now to volunteer for the cause of serving all men—in the name of Christ?



Evans from Three Lions

MONUMENT TO MOSLEM CULTURE

The chaste purity of line and harmony of decoration exhibited in Moslem architecture are expressive of the simplicity of doctrine which is characteristic of the Mohammedan religion. This is the tomb of Itimud-ud-Daula near Agra. It is of white marble, inlaid with black marble and colored stones.

Islam Is Brotherhood

The greatest strength of Mohammedanism today is its ability to transcend race, color, caste and nationality. It is the hope of Islam. Therein, too, lies the approach to the eighty million Mohammedans living in India.

The 80 million Mohammedans living in India comprise the largest bloc of Moslems to be found anywhere in the world. As landowners and peasant farmers, they number as high as ninety percent of the population of the Indus Valley, Baluchistan and Eastern Bengal. As shop-keepers and artisans they inhabit the larger cities of the North and even some districts of the South. They form one-third of the population of the Moslem world and one-fifth of the total population of India.

When the Mohammedan Arabs poured into Northern India during the eleventh century, the primitive reforming fire of Islam as a religion was somewhat spent. Zeal for proselytism had given way to another aim—the enlargement of the Moslem Empire. True enough, Hindu temples and their idols were plundered and smashed by the invading armies, and there were forcible attempts at conversion. But the conquerors of Hindustan soon discovered that to uphold Islam as a rigid policy, a sort of all-embracing Church-State, in which the kafirs (infidels) had no place, was most impractical. The caste system with its severe penalties imposed on those who deviated from it made the conversion of the Hindus difficult. Those who did embrace Mohammedanism came largely from the animists and the lower caste Hindus who could better their lot under the more generous and brotherly conditions of Islam. Persecution on the contrary often strengthened Hinduism and led to powerful reactions against the usurpers. It is not surprising therefore, that the Moslem leaders deemed it a far wiser policy to be content to rule politically, conceding to their Hindu subjects the status of dhimmis.

For several hundred years the Mohammedans thus enjoyed the position of conquerors and masters. It was the period of the great Moghul Empire, the golden age of Islam in India, notable for a galaxy of famous emperors—Akbar, Jahangir, Jahan Shah—under whose rule Moslem culture flourished and bore fruit in architecture, music and poetry. Great Islamic monuments of this period still exist today—especially at Agra and Delhi. And indeed, the chaste purity of line and harmony of decoration exhibited in Moslem architecture is expressive of the simplicity of doctrine which is a characteristic of the Mohammedan religion.

In the eighteenth century however, the Moghul court at Delhi ceased to wield any influence. There was weakness within and power without. The period was an ideal one for adventurers and opportunists. And so adventurers rose up all over India—those who were native to the soil, those who came across the frontier, and those who came from across the seas. India became a prey and a booty, and the contest ended only when England triumphed over her rivals and annexed the country to her possessions.

Under the new rulers the Moslems found themselves in a position of inferiority and humiliation. From having been the masters of the Hindus, they were now their fellow-subjects, under a government so pledged to neutrality as to appear indifferent to any contest between the two for wealth, office and influence. Persian was abolished as a court language and English became the medium of higher education. Its language shelved, its laws replaced, its prestige gone—Islam was now but a part of a subject nation, and a minor part at that.

Thus stripped of the outer trappings of power, Mohammedanism has had to turn within itself to find new strength. Without doubt it possesses such a force—and a strong one—in the idea of brotherhood. This is the inner tie that brings Moslems together and succeeds in creating an effective and equal brotherhood of believers. Not that democracy, in the political sense, or socialism, in the economic, are characteristic of Islam. On the contrary. But among all Moslems there is that general sense that all men—high and low, rich and poor, king and beggar—are equal in nothingness

"Our Lord!
Make us submissive to Thee,
And raise from our offspring a nation submitting to Thee,
Show us our ways of devotion and turn to us mercifully,
Surely Thou art the Oft-returning mercy, the Merciful!"

—Indian Prayer.

before the super-eminent greatness and majesty of God. Moslems are brothers, and they call each other that. In Morocco, in Java, in China and India, and even in a mosque in London—the Sons of the Prophet are held together by that great bond of religious brotherhood, revering the same Holy Book, written in the same sacred language, and bowing towards the same holy Mecca.

Their very ritual of prayer is in fact a symbol and expression of the tie that binds the Moslem people. The deep bows and inclinations of the head, the prostrations on the ground, the lifting of the hands in supplication—all these typify the reverential self-abasement before the Almighty. "Allahu akbar! God is very great!"—cries the muezzin as he gives the call to prayer—and that is what all true Moslems express even in the exterior details of their liturgy.

To the average Westerner the complete self-possession and lack of embarrassment with which the Mohammedan performs his rite of prayer is something of a surprise. In the privacy of the home, the seclusion of the mosque, or exposed to full view on a public road or crowded square—it is all the same. The act of worship is nothing to be ashamed of. Rather it is a confession of world-shaking faith—a symbol of the mighty bond that links Moslem to Moslem as brother to brother.

This deep-rooted and fundamental idea of Islamic brotherhood has had particular consequences in India. The Indian Moslems can no longer lay claim to their ancient power, but they can and do lay claim to brotherhood. Again and again this idea has been emphasized by Moslem thinkers and reformers. It was the theme of the poet-philosopher, Muhammad Iqbal, at one time the President of the All-India Moslem League. According to Iqbal, the salvation of Islam lay in a sort of Moslem internationalism. As he expressed it—"Islam is neither Nationalism nor Imperialism, but a League of Nations, which recognizes artificial boundaries and racial distinctions for facility of reference only and not for restricting the social horizon of its members."

The idea of pan-Islamic brotherhood has had notable results in India and a growing portion of the Moslems feel that their first allegiance is not to the geographical unit—India—but to Islam. Hence their demand for a separate Pakistan—holy land of the Moslems.

No doubt the greatest strength of Mohammedanism today is its ability to transcend race, color, caste and nationality. To deepen this idea and make it widespread, therein lies the hope of Islam, its chance for survival and new growth.

Schalek from Three Lions

Their very ritual of prayer is symbolic of the tie that binds the people of Allah. Here Moslems prostrate themselves in reverential self-abasement before the Almighty.

—Three Lions

The star and crescent moon of Islam are carried in a religious pageant through the streets of Karachi.

Paradoxically enough, the very principle of brotherhood which is the hope of the Moslems, is the key wherewith Christianity can enter into the hearts of the people of Allah. To approach the Mohammedans directly is almost sure to meet with failure. According to the ancient Law of Apostasy, any Moslem who leaves his faith to follow another is a traitor, not only to his religion, but also to his people and his family and is deserving of death. Under such circumstances the difficulties of conversion are indeed overwhelming.

But there is a way. Christians, living as Christians, showing by the example of their charity that they are brothers one to another and to all men in the greatest brotherhood of all—the **real** brotherhood in Christ, can prepare the hearts and minds of the Moslems for the acceptance of the true Faith. In this regard, hospitals, clinics and dispensaries are of the greatest importance. This is particularly true of those for women and children, where women doctors and nurses can give Mohammedan women the medical care they are so much in need of and which on account of purdah, they cannot receive from men.

"I shall accustom every man, be he Christian, Mohammedan, Jew or heathen, to look upon me as a brother."

—Charles de Foucauld

This month Our Holy Father asks us to pray especially for the eighty million Mohammedans living in India. We may never, never go to India, we may never meet even one Mohammedan, we may not be able to aid materially—but the charity of prayer is something everyone can give. Let us pray therefore, that the people of Allah, in particular the eighty million living in India, may soon come to know **true** brotherhood—in Christ.

Chota Bukhar--

Health Problem Number One

by

SISTER M. LEONIE TUMMERS, S.C.M.M., M.D.

Whether you call it chota bukhar in Urdu or malaria in English, it is still India's greatest health problem.

"Sister Ji," a breathless youngster runs into the dispensary, "please come quickly to pray over my brother; an evil spirit has taken possession of him and he is making him go all funny like this," and he demonstrates a convulsion.

"Nonsense, spirits do not do that," and turning to the doctor on call she says, "What shall we do?"

"Better go and take a thermometer along and bring the boy to the hospital," is the answer.

About fifteen minutes later the sick child and the whole family, all excited, arrive. The boy has a temperature of 107°. A quick history reveals the following: fever for a few days, treatment by a **hakim,** in coma twenty four hours, convulsions since morning, about nine hours. A blood smear shows an overwhelming malignant mallaria infection. The child is given quinine intravenously and all known measures are tried to bring the fever down. But too late. The child dies, and he is a boy, too! He could easily have been saved, if only . . . This ignorance and superstitition!

A woman drags herself into the office and has just enough strength to say, **"Chota bukhar** (malaria)," before she collapses. She is admitted. Quinine in heroic doses is given. Within twenty-four hours the fever is under control and after ten days she walks out of the hospital with **"Bahut salaam,** and many thanks; I will tell the whole village about this. There is so much **mausum bukhar** (seasonal fever) there."

Malaria, public health problem number one, not only claims over one million known deaths per annum (Who can count the innumerable unreported deaths in India's villages?), but also causes an incalculable loss of working days —a great economic disadvantage. It is responsible for much of the anemia in the tropics and therefore indirectly for a much greater number of deaths than the actual number shows. For example, the other day a woman was brought in from several miles outside the city. She had had chills and fever off and on for one month; the day before admission she had had a severe post-partum hemorrhage. The next day she was "not doing so well," so the relatives decided to bring her to the hospital. On inquiring why she was not brought earlier to the hospital, since she had so much fever, the laconic answer was: "This is the season of fever, almost everybody has it." Her hemoglobin was below ten with the red blood count accordingly, so we quickly gave her blood transfusions. She is on the mend now, but had she died her death would have gone down in the statistics as maternal death. The real offender, malaria, which sapped her blood and strength quietly and gradually would have escaped unmentioned.

Known to the Ancients

Fevers which occur every other day or every third day were known to exist long before the beginning of the Christian era. Hippocrates described them. As malaria disappeared with the drainage of swamps the idea grew that the fever had something to do with the bad air from these swamps—**mal**-bad, **aria**-air. It was not until the nineteenth century that Laveran, a French army surgeon, found the malarial parasites in the blood. Ronald Ross, working in India, after much labor proved the causal relationship between malaria, mosquitoes and swamps. He was so impressed by his discovery that he wrote:

This day relenting God hath
placed within my hand
A wondrous thing, and God be
praised. At his command
Seeking His secret deeds with
tears and toiling breath
I find thy cunning seeds
O million-murdering death.

I know this little thing a myriad
men will save.
O death, where is thy sting,
thy victory, O grave!
Before Thy feet I fall, Lord, who
made high my fate;
For in the mighty, small is
shown the mighty great.

And his discovery did save a myriad men and more. It amounted to the fact that for the transmission of malaria it is necessary to have: a female Anopheles mosquito; a person suffering from malaria whose blood contains the malarial parasite and who permits himself to be bitten by a mosquito, and lastly, the healthy person who is careless enough to allow mosquitoes to bite him.

Man Versus Mosquito

If, therefore, we can break this chain of events we shall have conquered malaria. In other words, if we can keep man and mosquito

apart, malaria will be wiped out. This seems simple enough, but man will be careless and mosquitoes will bite if they have the chance. Even army discipline has not been able to keep them apart. But the military have attacked the problem the same way the builders of the Panama Canal did. They make war on the mosquitoes and the mosquito-larvae. Mosquitoes breed in large quantities of water. Some species like clean water, others dirty; some like still waters, others prefer the edges of running streams. Where there is proper drainage the mosquito cannot breed, cannot multiply, and malaria is kept down.

After the monsoon there are always pools of water around the villages which no one bothers to clean up. The mosquitoes increase and multiply and the malaria season is there. Then too, the habits of the people are such that near the houses there are puddles of stagnant water—beautiful breeding places for the mosquitoes. Wells also are a constant source of malaria. Furthermore, there are millions who already suffer from the disease, a circumstance which accounts for much of the apathy of the people towards energetic control measures. Add to all this the lack of trained medical personnel and the unavoidable cost of public health work—and it is easily seen that to make India malaria-free is a gigantic task.

It Can Be Done

But it is not impossible and efforts are being made to improve the health situation. The efficient work of the army medical units in clearing endemic malarial areas shows it can be done. The army's method is to attack the malaria mosquito at all stages of its development. Land is carefully drained to deprive it of breeding places and great use is made of insecticidal sprays to destroy the adult insect. The soldier is made to protect himself at night with anti-mosquito cream, mosquito nets or veils and with protective clothing. The result of a few months' intensive campaigning has been that in the case of small reinforcement parties arriving in forward areas in Assam, the incidence of malaria was reduced from 80 to 10 per cent. In addition anti-malarial drugs are used as prophylactics when the risk of infection is increased.

The Bombay government too, has made an extensive plan for an amelioration of the province which includes anti-malarial work. A trained personnel is to be provided to give efficient action to the measures at hand. There is also the Malaria Institute of India which is maintained by the Government and which to a large extent co-ordinates the anti-malarial operations of the Central and Provincial governments. In Delhi within the last five years a very successful campaign has been in operation, including the provision of certain permanent engineering works at the cost of seventeen million rupees.

Already in the towns of India people are forced to close wells and prevent the accumulation of stagnant water in their homes and gardens where mosquitoes can breed. Once the villages receive satisfactory water supplies and sanitary arrangements, the same regime of depriving the mosquito of its breeding place can be introduced. Anti-malarial drugs such as atabrine are being distributed throughout the country wherever they are most needed.

Nation-Wide Campaign Needed

It is evident that a nation-wide campaign is necessary to combat malaria. The best hope of all lies in the fact that more and more people are beginning to wake up to the need and are expressing in newspapers and periodicals, as did one correspondent in **The Illustrated Weekly of India**—"I hope the day will not be far off, when we shall have an anti-malarial squad of trained men in every village and city in India. Many men in the army today have been trained in anti-malarial work and when the war ends and they are demobilized, these men can be given employment on anti-malarial duties in every city and village of India.

"Large numbers of young medical officers and others are being trained every year in the Malaria Institute in Delhi and many of these officers will be available after the war and should be made full use of by municipalities and district boards to supervise the anti-malarial work under health officers. I would rather see a separate service set up after the war whose sole duties would be the control of malaria. A service of this kind would be of inestimable value to the people of India. The health of the people would be improved and tuberculosis would be less common. When we think of the number of working days lost in India on account of malaria, the cost of such service would be infinitesimal in comparison."

"India still endures, but her civilization has declined. The ancient culture has been covered with a heap of dust which the long ages have accumulated . . . We must sweep away the dirt and poverty and misery from our country. We must also clean up insofar as we can the cobwebs from the minds of so many people, which prevent them from thinking and cooperating in the great work before us. The most horrible of all are those that grow up in the mind, which prevent one from discarding an evil tradition because it is old and from accepting a new thought because it is novel."—Jawaharlal Nehru.

Daily Review

by
SISTER M. ELISE WIJNEN, S.C.M.M., M.D.

Fully recovered, the patient leaves the hospital with all her goods and chattels. But the chart that remains tells a story of hard work and final triumph for the medical profession.

Towards the end of the afternoon, as the busy hospital day draws to a close, I try to take time out to go over the patients' charts, one by one. That is usually considered rather a chore, left to the last, done hurriedly or neglected entirely for more important matters, work more immediately and obviously connected with the patient's well-being. Yet when one comes to think of it, what an interesting cross-section of India's illnesses and misfortunes do these sheets reveal! Besides, without charts one sails the sea of medicine blindly. Only a daily and adequate record of the patients' complaints, findings, tests and treatments keeps one steering straight to the goal of complete recovery.

Take, for instance, Uma's chart: It is a good example of the way illness goes in India. She had her first attack of gallbladder trouble just about a year ago. The girl is only nineteen, and as thin as a matchstick, so she conforms in no way to the rule of "fair, fat and forty", which is as much a hindrance as a help in the diagnosis of gallstones, back home. Yet there never was much doubt in our minds about Uma's diagnosis. She had the typical upper abdominal pain, tenderness, fever and nausea. But the symptoms subsided under treatment and when all was ready for operation, Uma and her relatives were not! They simply would not hear of it. So we had to let her go, hoping that the next attack of pain would bring her to her senses, before additional damage was done.

We should have known better than that! From then on Uma was back in the hospital **five** times, with the same complaints, besides having innumerable mild attacks at home. At one time it was too hot for an operation, another time the mother-in-law was reported to have died, then a distant relative fell sick, and when the usual excuses had petered out we were told that the husband had to be summoned first . . . and he was in Africa, with the army! Anyhow, here is the permanent record of Uma's troubles, mostly self-inflicted: a spiking fever chart, dotted with injections and treatments, a laboratory record of increasing anemia and leucocytosis, and the endlessly repeated story of failure to coax the patient into an operation.

This last admission we finally cut through the Gordian knot. We refused to let her in the hospital unless she promised to let us operate the next day. That was a rather hazardous decision, for she was badly jaundiced, dehydrated and feverish, but it proved to be the only way out of the dilemma. Her people gave in, and after a quick preparation, consisting of subcutaneous fluids, glucose by vein, sedation, internal and external cleansing, and a prayer to St. Jude, we put Uma on the operating table and removed the little bag of stones that had been causing all this trouble. After a few days of touch-and-go she settled down to business and now she is well on the way to reoovery.

This is going to be a good chart for teaching purposes. The way the temperature line has flattened out, the gradual falling off in injections and drainage, the improvement in the diet and clearing of the jaundice—it is all there in black and white, a cryptogram to the uninitiated, but a story of triumph for the profession! Besides being a permanent record, it is a useful guide for present decisions. Now we must work on the anemia, and write down the removal of the sutures and the order to sit up tomorrow. We really should record the first smile after the operation also, and the first meal of curry and rice! An

Indian without "dal-bhat" is almost as unhappy as an Irishman without tea and potatoes!

Here is a brand-new chart, with nothing on it as yet but a name. It belongs to Rama, admitted today to the nursery. Poor little fellow, for all his five years he certainly has had his share of Indian misery. His father is a coolie, whose entire earthly possessions consist of a small rented room somewhere in the bazaar, a few rags and clay pots, the clothes on his back, and the money he earns day by day, ferrying loads back and forth on his head. The child's mother is dead. For three months the father has dragged the poor boy from one dispensary to another, trying to find a cure for the constant chills and fever, the increasing weakness and loss of appetite, and the racking dry cough that keeps him awake at night. They have tried homeopathic, Ayurvedic and even some Western medicines, none of them long enough to make any impression on the stubborn fever. Lately people have been saying that the boy has a "spleen", and as he has heard that we have especially good medicine for that disease, he has at last come to us for treatment.

One look at the youngster is enough. He is doomed, unless someone really takes him in hand, forces his shiftless parent to have him treated properly and regularly, feeds him up and thus gives him a chance in the rough and tumble of Indian life. Obviously, his is a case of kala azar, badly neglected despite the easy availability of treatment in a large town like Patna. The father does not realize the need for prolonged treatment. It is too much trouble and too slow in response. Every chance acquaintance has a different remedy to recommend, from tinctures applied to the toes to amulets worn around the waist, from nauseating mixtures to minute homeo pills, the one even more useless than the other.

Well, we managed to persuade the father to leave the boy with us for a few weeks. There will be quite a change in the patient and in the chart during that time. At present it looks bad: temperature 103°, hemoglobin 25 percent, weight 35 pounds, kala azar test four plus, refuses to eat, etc. But before long you will hardly recognize the youngster. He will be feeling fine, and his appetite will be the pride of the nursery.

Other charts do not take so long. There are the post-operative cases, who need a record of the fluid intake and output, general condition, drainage, etc. There is the inevitable heart case, whose pulse rate and edema have to be watched. A poor boy dying of tuberculosis needs his daily and nightly dose of morphine checked. A couple of abscess cases must have the removal of the pack recorded, and a man with typhoid must have his medicine changed. He is entering the third week, and his restlessness is fading into drowsiness now. Others will be going home today. A final note must be added, indicating the degree of improvement or the lack of it. A surprisingly large number of cures are possible in an Indian hospital. Most of the diseases are curable as well as preventable, and only a small percentage belong to the "chronic" group which fills the hospitals at home: arthritis, heart disease, diabetes, nervous and mental disorders, etc.

Yes, medical practice in India is both interesting and satisfying. The main drawbacks are the abysmal poverty and the ignorance which so frequently prevents adequate cooperation on the part of the patient. If her sick could be cured, India would be one of the healthiest places in the world! It will take more than sanitation and preventive medicine, which in themselves are useless without the cooperation of the public. A living wage, a higher level of education, and adequate provisions for good medical care are needed to build up and maintain the standards of health.

Public Health in the Bombay Plan

A definite step towards an adequate public health program for India has been proposed recently as one of the objectives of the newly-developed Bombay Plan. The Plan, which has been brought forward by some of the country's leading industrialists, calls for an expenditure of 30 million dollars in an extensive modernization program.

According to the Plan—most of the capital is to be spent in the increase of industrial production. Housing, agriculture and communications follow in order of allotments. Next come provisions for education, health and miscellaneous items. The amount to be expended on health is equivalent to approximately one-thirtieth of the total capital.

The public health and medical proposals in the Bombay Plan have been made under four headings—proper arrangements for sanitation and water supplies in villages and towns (Only 253 out of 1,471 towns in British India had protected water supplies in 1939.); a dispensary for every village; general hospitals and maternity clinics in the towns, and specialized institutions for the treatment of tuberculosis, cancer, leprosy, etc.

The village dispensary, according to the Plan, would be in charge of a qualified doctor and two qualified nurses, one of whom should be a trained midwife. (Incidentally, this would require more than seven lakhs of doctors and 14 lakhs

of nurses for the villages alone!) The dispensary would be the main agency for destroying epidemic diseases, and for dealing with maternity cases.

Hospitals, which would be built in the towns, would also serve as centers for expert advice and specialized treatment for the surrounding villages. The Bombay Plan reckons hospitals as units of 40 beds each and at the rate of one to every 10,000 people. On the average, an Indian town would need a hospital of about 80 beds.

In addition, maternity hospitals at the rate of 30 beds to an average town are needed. (In the villages, the dispensary midwives would deal with the mothers in their homes.) In this way it is reckoned that 1,600,000 of the two hundred thousand of mothers who die in childbirth each year could be saved.

Further provision is made for special institutions for tuberculosis, leprosy, cancer, mental disorders, etc. According to estimate, about 150,000 beds would be needed for these cases.

All told, the Bombay Plan's medical and public health allotments come to Rs. 281 crores (A crore is equivalent to ten million rupees or three million dollars in American money.) for non-recurring costs and Rs. 185 crores a year. When the Plan was first published such huge figures seemed outside of practical policies. That is hardly the case today, for people are rapidly adjusting their ideas about what they want.

The fact is that India cannot afford to be without such services and the events of the past year have served to emphasize the grave risks her people run when they are not adequately protected against disease. At present in some parts of Bihar there are more deaths than births. In Bengal there is little doubt that sickness did as much, or more, damage than famine. No country can progress until such dislocations of national life are made impossible.

Note: The material for the above article on health measures under the Bombay Plan is taken from The Illustrated Weekly of India, October, 1944.

The Mission Clipper

CHOLERA EPIDEMIC—CALCUTTA

A press report, dated May third, tells of the severe epidemic of cholera now raging in Bengal. Seventy persons are reported stricken daily. About 30 per cent of the victims die. There are 18 cases among British military personnel, but United States Army doctors say there are no cases of Americans being attacked in Calcutta.

All Americans in the area have been inoculated against cholera. The Air Transport Command refuses to fly any passengers who have not been inoculated within the past 60 days.

The epidemic rivals that of 1943, when 216,428 persons died in Bengal. The average number of deaths from cholera in the province is 53,266 annually.

The worst week of the Calcutta epidemic was the one ending April 14, when 454 persons were hospitalized and there were 148 deaths. It is likely that there were many unreported cases among the poorer classes of the people.

The newspaper **Statesman** charged that the failure to prevent the sale of food from curbside stalls by street venders was one of the prime causes for the present epidemic. It ran a recent series of pictures which showed the sale of food in the open, near sewer drains.

NEGRO HEALTH

The admittedly serious health problems of Negroes were among the issues discussed recently at a hearing before a Senate committee investigating wartime health and education. Dr. E. I. Robinson, President of the National Medical Association, conducted the discussion. In his report Dr. Robinson pointed out that the mortality rate is 30 per cent to 40 per cent higher among Negroes than among whites. The average life expectancy for Negroes is 10-12 years shorter than for whites. The tuberculosis rate in the United States is regarded to be three times as high as for whites, and even higher in certain areas of the country and in certain age groups. Venereal disease is a more acute problem among the Negroes than among the whites. The maternal and infant mortality rate among Negroes is double that among whites.

As Dr. Robinson indicated, we cannot base these serious problems merely on the basis of population percentages. The needs among Negroes are disproportionately great. In some states there are not enough physicians, nurses and social workers, to cope with the problems of the Negro population. In Mississippi, there is one Negro doctor for every 15,000 or 20,000 Negro Americans. We must see to it that we keep up a continuous flow of Negro graduates in medicine. The facilities of Howard and Meharry Medical Schools must be augmented and must be used to capacity. Governmental subsidy must be made available for the medical education of the Negro and the subsidy should be placed into the hands of the students of the schools of medicine rather than be entrusted to a supervising state. Finally, the schools of medicine other than Howard and Meharry

should be stimulated to admit competent Negro students so that the number of Negro graduates each year may number three to four times the present annual number, that is, 30 to 40 Negro students in place of 8 to 10 as at present.

—Hospital Progress

FRANCISCAN MISSIONARIES RETURN TO HONDURAS

The return of Franciscan Missionaries to Honduras, Central America, where an extensive mission field has been recently assigned to them, is an historical event. The earliest missionaries in that country were Franciscan Missionaries who came there at the time of the Spanish Conquistadores. In 1825, after over 300 years, the Franciscans were expelled. Since then only a handful of priests have been ministering to the people of the whole country.

—Jesuit Missions

CURE FOR SLEEPING SICKNESS

Para-arsenosophenylbutyric acid is a long name, but it gives hope of a short cure for the scourge of Africa, sleeping sickness.

The compound, composed of arsenic, butyric acid and another element, was developed in collaboration by Dr. Harry Eagle, Dr. G. O. Doak, Dr. H. G. Steinman and Dr. H. J. Magnuson, medical researchers of the Public Health Service in the agency's research and postgraduate training center at Johns Hopkins University, Baltimore.

Tried In Africa

Last summer, Dr. Eagle took it abroad and used it for wide-scale experiments in cooperation with the sleeping sickness services of the Gold Coast, Nigeria, the Belgian Congo and the British forces in West Africa.

More than 200 human patients were treated with seeming success in the field trial, and it is expected that the study ultimately will include more than 1,000 persons treated. Similar experiments are planned for Northern Rhodesia, French West Africa, French Equatorial Africa and Sierra Leone. The wide geographic distribution of the cases treated assured the inclusion of a variety of strains of the trypanosomes, the sickness-causing organism carried by the tsetse fly.

African sleeping sickness makes large areas of the continent uninhabitable. If the new treatment is a cure—and the experimenters will not say it is until they have had a year to observe the apparent cures—it will have the advantage of curing in two weeks or less a disease that formerly required three or four months of laborious treatment. The compound holds promise thus far only in cases where treatment is applied early. Where the brian and central nervous system have become affected there is much less hope of lasting good results.

IRELAND FILLS MISSION VOCATIONS

"Ireland is doing beyond all expectation and making up for the deficiency of vocations that has recently occurred in other countries like France and Spain, which formerly were pre-eminent in spreading the light of faith among pagan nations," said Bishop Morriscoe, of Achonry, Ireland recently.

"In these days," the Bishop continued, "crowds of our young boys and girls are making the sacrifice and dedicating their lives to the missions. Yet the cry of the Holy Father is for more and still more."

We may add—Will America, "the hope of the missions," also come to the fore?

WESTMINSTER DOCTORS' GUILD

From England news has reached us of the plan to form a guild of Catholic doctors in the Westminster diocese. More than 350 doctors have been invited to meet at the Archbishop's House with the object of organizing the guild.

MODERN MEDICINE IN THE NEW CHINA

Modern medicine must likewise have a prominent place in strengthening China. Crude relief measures are stop-gap efforts in the face of tragic calamity. For tomorrow there must be tens of thousands of trained physicians. There must be hospitals. Supposing there were to be a 50 bed hospital for every 50,000 people throughout China, this would require 9,000 hospitals. What huge proportions every program assumes which touches that great colossus China! Men of courage and conviction are needed for such a situation, men who are guided not merely by the pale candles of logic and human reason but men who are impelled by the hot surging fires of Christly love and Christian conviction—**Chinese-American Bulletin,** April, 1945.

Please pray for the repose of the souls of:

Most Rev. James P. McCloskey, Bishop of Jaro, Philippine Islands.

Very Rev. Pancratius Pfeiffer, S.D.S., Rome, Italy.

Mrs. Anastasia R. Paulus, Chester, Ill. (Mother of Sister M. Dolores, S.C.M.M. and Sister M. Felicia, S.C.M.M.)

Mrs. Winifred Ryan, New York City.

Mrs. Margaret Nelson, Baltimore, Md.

May their souls and the souls of all the faithful departed, through the mercy of God, rest in peace. Amen.

News From Home and Abroad

WASHINGTON, D. C.

Con-gratulations!

June again—so we begin with our graduates. Two sisters from the Washington House of Studies have completed their work for receiving their college degrees.

Sister M. Renee received her Bachelor of Science degree from the George Washington School of Pharmacy, Washington, D. C. Sister Renee, who is from Brooklyn, N. Y., was professed August 15, 1941.

Sister M. Frederic has been graduated from Trinity College, Washington, D. C., with a Bachelor of Arts degree. Sister attended Manhattanville College for one year before entering the Society. She was professed August 15, 1941. Since then she has taken a course in X-Ray Technology at Fitzgerald Mercy Hospital, Philadelphia, and completed her college work at Trinity College.

ATLANTA, GEORGIA

Child Health

Encouraging reports of the health program which is being carried on at Our Lady of Lourdes school in Atlanta, Georgia, have come to us through Sister M. Regina. Physical examinations, skin inspection, eye and ear testing, weights, and record keeping, are included in this school work. The Public Health Doctor, who is working with the sisters, studied medicine at Temple University in Philadelphia.

SANTA FE, NEW MEXICO

From the Santa Fe Catholic Maternity Institute, Sister M. Theophane writes of the classes for mothers which are being held at the school . . . "Twenty women, all of them very enthusiastic and interested, registered at the beginning of the series. Sister Helen teaches them—formal lecture style for one hour—followed by tea. After the tea, there is another hour of sewing. Those having a perfect attendance record for the course receive diplomas."

INDIA

MARY GIRI

Seminarians Evicted!

"Our entrance into Mary Giri Novitiate here at Kottayam, Travancore, is an event which will go down in the history of this diocese," writes Sister M. Vincent. "Seminarians were 'evicted'—they were literally 'put out'—to let the sisters in. The seminarians' classes ended on Dec. 13th, and we moved in on the 14th. Our lorries had to wait outside loaded with furniture while the seminarians quickly packed their possessions into two rooms. It is a fairly large house, and the grounds (sixteen acres) are set out in rubber trees. It is interesting to see the coolies tap the rubber trees every morning, and collect the white milky fluid, which is fumigated with acid and pressed into sheets that become dark brown when dry. There are also papaya, cocoanut and pineapple trees. The latter are growing wild, so will have to be transplanted."

Altar Bread

Sister Vincent also tells of a new occupation—"Recently two sisters from the Apostolic Carmel nearby came to teach us how to make altar breads. It takes about three hours to grind and sift the flour from the raw wheat. Then two hours to make a week's supply over a fire of cocoanut shells. Everything is done very primitively, the same as has been done for hundreds of years."

RAWALPINDI

Golden Eggs

In India, just at present, every egg is a golden one. "The patients must have eggs", is the order of Sister M. Alma, M.D. "Other articles of food are comparatively easy to obtain," explains Sister, "but eggs—— In desperation Sister Nicola sent our chief cook out to the villages. He left early in the morning, but had not returned at 10:30 P.M. However, next morning he was in the kitchen, bright and early. He had gone to Taxila twenty miles away, and had been promised eggs. The man was completely out of eggs but expected some that day, but they had not arrived by the time the train left at 9:00 P.M. But he had a **'bandobast'** (arrangement). Yesterday we received about thirty dozen."

Not Rhyme But Rhythm

The nurses at Holy Family Hospital have a gramaphone. Sister Alma Julia thus describes this novel form of entertainment. "Although about fifty records have been donated, there are only three or four which are special favorites of the Indian nurses. They do not understand the words, but the rhythm appeals to them. These particular records have the right time for their native dances. I do not know the names of the songs, but have heard a line here and there, 'O Susanna, don't you cry', and something about 'I'm lonesome, Caroline'. You should see them doing a solemn rhythmic dance to some of these tunes.

"India is a mixture of new and old—but the war has hastened

things," continues Sister Alma Julia. " 'The Song of Bernadette', U.S. Army film, came this way, but could not be shown outdoors as scheduled because, as the Indians say, 'It rained elephants and camels'. The rain continued for about a week, and in the meantime the movie had to travel elsewhere. The secular nurses saw 'Men of Boystown' when it came to Rawalpindi. Since eighty per cent of India still lives in the villages, many of the nurses have never seen a motion picture or used a telephone."

Wanted—Priority!

The sisters in Rawalpindi are having the universal difficulties with permits, etc. Sister M. Nicola adds a note to say: "We are starting to build a room upon the verandah of our house, so we will have at least a room for the night sister to sleep. When that is finished, we intend to build two more rooms on the hospital verandah. But it is very difficult nowadays to get the men and materials. Much of my time is spent in cycling through the city, trying to obtain all the necessary permits. Everything is regulated by them—building material, cement, coal, grain, etc. Sister Alma Julia needs permits to buy several drugs, also."

PATNA

India Shivers!

The following may help to tide you over the heat of the coming summer. "Patna is having the coldest winter in man's memory", writes Sister M. Elise, the weather reporter from Patna, on February 5. "All over India unusually cold weather has occurred." "But," interrupts Sister Laetitia, "actually it is not really cold at all, just slightly chilly." "Of course, it is all relative", explains Sister Elise. "We shiver at 45 degrees here; the poor people are really miserable. They have practically no woolen clothes and only puny fires. We have had two or three newborn babies come back after a week or so at home, almost dying of the cold. Fortunately the incubators, improvised as they are, together with subcutaneous saline and tube feeds, have pulled all of them through."

Hospital Addition

"On January 10, Lady Rutherford, the wife of the Governor of Bihar, formally opened our new building," reports Sister Ignatius Marie. "She was accompanied by her secretary, Mrs. Porter. Bishop Sullivan, S.J., Fathers Loesch, Moran and O'Leary, were present, as well as many leading doctors, Rai Bahadurs, Rai Sahib, etc. St. Xavier's supplied the decorations, flowers, plants and flags. A group of students from the Patna Women's College conducted by the Apostolic Carmel Sisters helped serve."

Indian Tea Party

"The nurses were given a tea on February 2", continues Sister Elise. "They enjoyed the play and singing, but were very shy about the tea-drinking. We try to teach them the Western manner of eating and drinking leisurely—making conversation in between. However, Indians like to eat facing the wall, in a strictly business-like fashion."

Mary Ward's Tercentennary

"The school girls at the Institute of the Blessed Virgin Mary Convent, celebrated the tercentennary of Mary Ward's death with a play based on her life. The hall was well filled with priests and sisters. His Excellency, the Jesuits, secular priests, the Christian Brothers, the IBVM's, the Apostolic Carmelites, and several Indian Sisters, made quite a large audience for a mission diocese."

So end the social events of this month.

DACCA

From the Mitford Hospital in Dacca comes a report by Sister Thomas. "The hospital has been admitting many cholera and meningitis patients, and many last stage tubercular cases. The latter are mostly young boys with both lungs affected. Generally, there is no chance of recovery, but we can at least help them to tolerate the pain, and die peacefully. If there were only a sanatorium for terminal cases so much good could be done for them."

S.O.S. -- FROM HOLLAND

Now that news from Holland is coming through, we have learned of the needs and distress of our sisters there. In the course of the war they were bombed out and burned out when the upper story of their house was struck by incendiary bombs. Linens, habit material, household goods, everything was destroyed. The sisters have sent an urgent appeal to the Motherhouse. But we cannot fulfill it without your aid. Whatever you can give of linens, household goods, or the wherewithal to buy materials will be gratefully received. There are forty-six sisters in our Holland house who need your help. Will you give it?

PRAYER TO THE SACRED HEART

Heart that makes solitude into a great people:

We ask Thee for Thy love.

Heart that makes discord into a united people:

We ask Thee for Thy love.

Heart in which the whole world becomes Thy people:

We consecrate ourselves to Thy love.

Overflowing Heart, overflaming Heart, overstorming Heart:

Be loved, Love, everlasting Love, be everlastingly loved.

—*From "Litany for the Feast of the Most Sacred Heart" by Gertrud von Le Fort.*

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